RALPH SACHS, M.D.
An Oral History Interview Conducted by
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FELDMAN. Ralph, how did you happen to come to Southern California?

SACHS. I was recruited by the Commission on Public Health Care in Los Angeles, having completed my work in public health in Driscol, Washington; and I was looking for greater fields in which to apply some of the public health principles that were good in medicine and could be implemented through community support. I heard about the position and the possible opportunity to apply my experience in the chaotic program in as large a community as Los Angeles itself. I came down for an interview with the Commission; they seemed satisfied with my background and my abilities.

FELDMAN. What about your background?

SACHS. My background is kind of interesting. I started off in public health back in Michigan. Having graduated during the depression years, I took a position with a children's foundation, called the Cousins Foundation, to examine children for eye defects, visual defects. In the rural part of Michigan, having just finished my residency in '38, it seemed quite an opportune paid position. I could finance my activities and obligations. I would travel throughout the State of Michigan on this eye program and in my travels I found the best applied work in the Health Department. I had this tenured position for three years and I saw that maybe, if I ever settled down, I would like to be in a community where I could apply some of the public health attributes. In three years' time, I was given a fellowship in public health and went back to the University of Michigan for my public health

work. My first position was in the middle of Michigan where a number of chemical companies were located. From there I was plucked, so to speak, by the Selective Service to go to a very secret project in the State of Washington which turned out to be the top health project emanating from Washington. There I was given the opportunity again to apply principles of public health. I was impressed by Californian and, in my mind, I always wanted to come back to California because my wife had lived here and her family was here. After long negotiations I did come down. The first thing I became aware of was the desire for the new public health commission—the Commissioners were headed by Dr. Frederick Gasper—to become very aggressive and effective in carrying out some of the learning's of medicine in California, and in Los Angeles. This was not being done by then-health officer Dr. George Uhl. There seemed to be a lack of communication between the Health Officer and the Commission.

The Commission was very pushy in trying to get Dr. Uhl to come up with a program. It turned out that what he needed was some help in trying to implement programs that were rapidly coming right about the same time. For example: immunization for polio. This was back in the days when polio immunization was just coming to the front. In little more than two weeks we had mobilized a system whereby children and others were immunized against poliomyelitis. We set up a system of clinics in health departments scattered throughout the City but also found other spaces like trailers, fire stations, and other places where we could reach the public in this program. There was a matter of supplies, of outreach to people: a matter of community organization, a matter of fixing a crisis, for the

incidence of polio was very high, very costly for the county; now this new Salk vaccine was the opportunity to do something to prevent the spread of the disease. It was very successful. We dealt not only with the private practitioner through the LA Medical Society, but also through our network of health centers, from which we went on to implement other programs. As an example, the tuberculosis clinic went on to give chemotherapy, which was a rather long program where the patient would come in very week to receive some treatment. The chemotherapy program was more effective and easier to handle than earlier efforts and was a credit to our network. We lacked many of the needed facilities: x-ray equipment, staff, and the like. It was not an easy matter to implement our building program, to program it. Most of the money was going into the hospitals, and we had the opportunity to point out that the presence of a program through the health centers was as appropriate as hospital beds. So through many hearings and the introduction of our program to a state planning group, we were able to build, as I recall, health centers in the northeast and other towns of Pacoima, Canoga Park, the Van Nuys area, and Wilmington, and in the southwest part of the city at Western and Exposition, where other programs were being implemented. We went about the matter of equipping and getting help for the service to be rendered, which was primarily venereal diseases. At that time syphilis, gonorrhea were the known sexually transmitted diseases hard to prevent; it was a matter of treating patients. Tuberculosis was a control program to make the patient non-communicable through chemotherapy and with guidance and casework with the families in our TB clinics. We saw our maternity clinics

more in terms of preventing complications in pregnancy and we attempted to provide for the prematurity that might occur amongst the newborn. In Sanitation, we implemented food inspection programs, more inspection of our water supplies and wells. Our occupational program built up a laboratory to take of the milk testing, disease testing, blood, and the like. When we got to the matter of equating the amount of work to be done with the number of people that you need, we got very popular program of budgeting which was the key to financing in those days: how much work a doctor could do and how many patients a doctor could see in a given period of time, how many clients s nurse could see, and how many clients a social worker could see, how much a clerk should do, how many inspections santarian could do in a days work. Well, we worked out formulas for all these and measured the volume we had in the every health center with man power, and we would go to equate the basis of a doctor being able to see 10, 12 patients in what we call a clinic sessions with how many clinic sessions were needed and how many doctors and, then, whatever the billing rate we paid them.

FELDMAN. How long was a clinic session?

SACHS. Half an hour. We did the same thing for the nurses and the santarians, and the clerical personnel were measured by the hours of work. We set out trying to establish a budget which was useable and then recognized by the city administrator office responsible for making up the budget and assigning personnel in the city. That was a very successful program and noted throughout the country: how a large organization could go into from budgeting and reasonably establish a cadre of people to serve the needs. As time passed, we

saw a need to keep service veterans, which meant an increased program and tight budgeting. We were able to find the weakness in the program, where a full load of not being carried, and transfer funds to programs and people over whelmed by the amount of work they had to do, and we made ends meet that way—without going back to ask for more money. When there was a sort of balance, then we had to go in to budget money to take care of the increased load and that was based on how much tax money was coming in and how much could be allocated to us. I was very surprised and it was very pleasing and gratifying to us to be able to carry that out.

You might ask where this volume of work came from, who our clients were. In those days the client was actually a family: a mother, a father who could not afford to pay a private physician, and we were left with those who could not afford to pay for service for the treatment or the prevention of some of the communicable diseases. In this respect, when we'd go to schools for immunization programs, we would see the mother prenatally; we would see the wage earner or the mother who had a communicable disease—perhaps tuberculosis or venereal disease--who could not afford a private physician. MediCal was not sophisticated then as it is today, and it was left to public health clinics to take of care this sector of the population and that usually follows with the demographic findings about the low income groups who were in an ethnic basis Black, Chicano, low income white families. We took up some of the slack in treatment for the communicable diseases. This went along very well, but it probably was too good to last. We got into a pivotal arena. Somewhere along

the line, the City Councilmen and Mayor Yorty found in the constitution of the State that the county was responsible for such care of the needy. Their interpretation led to combining health departments as a matter of efficiency.

FELDMAN. Combining city and ----?

SACHS. Combining city and county health departments. There was a fear raised about this tug of war for many months and finally the County took over the City department and thought they had solved the problem in saving money. But it turned out that the money-saving was insignificant in terms of the service to be rendered. Rather than having a system of decentralization, which we had, we went into the county bureaucracy. I might mention at this time the difference between what the city had, which was delegating responsibilities and the accountability to health officers in the health centers who had the districts of the city, versus the old bureaucratic type of system that the County had. In many of their places a bureau chief would run a program in a local area regardless of whether the bureau chief was in maternity or child health, venereal disease or tuberculosis; he would dictate program to the health officers of the districts.

FELDMAN. What was your position in the City Health Department?

SACHS. That position was executive officer. I think one of the things that Dr. Uhl allowed—he was permissive—and we carried out programs and he would see what I had done. We did have a good program. When it came to costs, the sanitation and environmental health was practically financed by a permit fee. We had programs where we got large grants for venereal disease control, these paid for most of the work. We also brought in, through the U.S. Public Health Service,

projects on cancer control, on heart disease. We were interested in how we applied our program for tuberculosis, so grants were made in regard to tuberculosis control. Actually, I would say off hand, adding up the figures, about 85 percent of our program was paid for by outside money when the County took over. Most of the employees went over to the County. I want to mention at this time that the city transferred the department by a one person majority vote of the council: eight to seven. There was a lot of sentiment about it and we realize now that the city lost a lot of its direct responsibility in terms of serving the Councilmanic Districts where council members could call on the health district programs. As time went on, there was certainly compromise as to activities between the bureaucratic type of programs and the delegational of responsibility, the decentralizations of activities and responsibilities of the health officer versus the bureaucratic type. In this program we had all levels of service: the doctor who was really the communicable disease control officer and the administrator, the nurses, the field nurses, the social workers who counseled the family, sanitarians, health educators, outreach people—so we had a good network in the community of reaching the public in terms of services needed in contrast to the county system in which the bureau chief would delegate “you shall do this, by such and such schedule.” That interfered with the atmosphere where the health officer could be on his own and explore various ways of getting his program across.

FELDMAN. When did this occur?

SACHS. 1964. By that time, sad to say, I had left the community and the health department. I was a little bit perturbed by what had happened and I went on to other fields. What I certainly should comment is what later happened. I did come back to the County in 1972 after service for the Ford Foundation overseas. The combination of the two health departments, the City and the County, perturbed me a great deal and I didn't care for the way the county and the bureaucracy were running the departments. Therefore I sought other fields. I was attracted to the nursing home installations that the Hill Burton Act brought to the community, health clinics that the FHA brought to the community—a stimulus to build the nursing homes at that time. There was great influx of entrepreneurs who were building nursing homes to take care of the aging. There was a wide distribution of nursing homes and the type of clientele they would have, in terms of their conditions, the quality of nursing care, and the like. I went with a private nursing home operator called United Convalescent Homes and tried to instill into the management of the nursing home the building into its program of a system of proper nursing care, proper nutrition, proper sanitation. I got into a situation whereby again the impact of a private payment for the service barred not an ideal, but a practical way of caring for the patient.

At the height of this conflict, I was offered the opportunity to get back into the field of public health activities through the Ford Foundation. This brought me to India, where we had a program to kind of balance the population. As it turned out, we founded the county-agent type of program where a county agent near the farmer in India was instrumental in teaching him how to properly plant his seeds, how to

fertilize, how to water so he could have better production on his land to feed the people who are needy in terms of how much, how many calories they need for their food intake just for proper growth and for proper health. In this it was necessary to control the size of the family because they were way overboard in terms of the number of mouths to feed and what the production was. The idea was established of a system of county agents that would be the equivalent of a county health department, to protect the families in regard to the high mortality rate, to the size they could handle with their problems of health, nutrition and the like. To do this, they came up with the idea of an establishment of typical health department in terms of the clinics, of sanitation, water supply, nurses to preserve that family structure, not overburden it by the number of children they were having and couldn't take care of. In the culture of India, the born child is necessary for the family to exist. In the midst of all this was a method by which inserting a vaginal loop into women of child-bearing age was thought to be, at that time, a better way of controlling the size of the family, to balance the food production, and trying to establish health departments which would be very costly compared to the few pennies that loops would cost. This idea spread across the province of the state like wildfire; it spread to the whole country as an answer to it all. We used the health set-up as a means of contracting and using the family planning network as a means of protecting the family. Some of the other health ideas ran through the country—and other countries in Southeast Asia—as a matter of fact thing to do.

The program got into training the doctors how to insert the lupus loop, and the nurses to go out and talk to the mothers about health education processes. We ran into how to supply the various stations that we had to establish in a country that needs better roads, better communication, better systems of communication, and the like. But they did pretty well and we were satisfied that the program was accepted, more so than some of the programs that we have in this country. It went on and the Indians were able to take over this program. We were hired by the Ford Foundation and I was in a District of West Bengal, where we established clinics and it worked pretty well.

Then there came a time I thought I would go to other fields, again to apply the principles for family health, not just control family size and food supplies. At this time Pakistan was in the need of a consultant, so I went to Pakistan and I found there that they carried on the program a little differently. The program there was to monitor contracts with three different agencies that were sending workers into the field. One was a population consultant who was setting up and testing and evaluating such as the University of Berkeley Public Health Department of Education, which came in to do a number of evaluation programs. They offered a different program in East Pakistan, now Bangladesh. They brought in people to train people in the work of evaluation and testing and production. They found the contractors did not always use the money as was expected. They used money generally to make profits. The research interns and the school representatives—professor's assistants—were submitting their papers for credit rather than payment. Then we put in a system that we'd pay on a voucher basis:

we would allocate the money pay on a two-year basis, have the agencies use the money as they thought fit, and we would pay as we went on and they fulfilled their contracts. This was not 100 percent appreciated by the various agencies involved. However, it was a pleasant experience in that we had some accomplishments in terms the people coming out would do what we contracted for. Most people came out for reasons that were involved, as they had faculty who could be assigned a panel of so-called experts you could draw on in trying to hire outside people who could go into the program. The Population Council established professional groups, a lot of demographers and statisticians in the industry.

This went on until I completed my contract, and then sought the opportunity to go to the University of Hawaii School of Public Health and Administration. It was a young school when I got in there late '60s and in turmoil in terms of applying teaching principles to student groups that at times were raising cain….

FELDMAN. Not sugar cane?

SACHS. No, not sugar cane (laugh). They had answers for everything. The bottom line was they had answers for nothing, and they turned to the people who had had some experience. First they didn't want to hear from this experience: they could do it better, but "better" was not coming to the surface at all, so they asked me for help. We went through some heartaches and headaches with them at that time. I was received well in this experience, wanting positive things: getting and using the university campus to recruit people. I had the opportunity to go to the World Health Organization, and some of the programs got me into

Indonesia, and brought me into Thailand, South Korea, Hong Kong, other places like the Philippines. That was on a solid base, to work with the governments in establishing programs. This was an enlightening piece of work. I left recommendations on how they should manage in terms again of child health and family planning, maternity care, how they could apply new techniques and technology to their people in a system of distribution of clinics and stations where they could reach the public, communicate better, etc. The best was given to them in papers written and put on the shelf by the HMO. One outstanding example was in Thailand, where the federal government supported the activities throughout the country excepting the Bangkok region, which was declared a metropolitan region, you know, they were really an entity that supported itself, so instead of going to the federal government for help, they had to stand alone. They were very lucid about their needs, so the idea was put across "why not give Bangkok a problems status" where they could tap federal funds. This was done, by a very energetic official in the metropolitan area and it worked out pretty well. It was kind of an advancement that to finance a program was to hook it up in the structure the government, trying to put into that structure so they could gain support. Only the metropolitan area in Bangkok became a problem type of support.

When I was at the University in Hawaii, another assignment I had was to monitor a program in Guam they needed assistance in the establishment of services there—a health center. I was able to recruit some graduate students to go to Guam and, under contract, apply their knowledge to the needs of the territory.

We visited there about every four months to see if the program was running properly. I then was able to establish, at that time, a planning group that brought some people to us to lay plans for the medical needs for the territorial government of Guam.

With these highlights in the University of Hawaii in the midst of trying to establish health centers throughout the islands, and each island, we must note, is the equivalent of a county—trying to promote activities in Maui and the islands of Hawaii and Owahu, Kauai, were county set ups. Their set ups also included hospitals, whose hospitalization field health service after the war was taken over by Hawaii. Most hospitals in the outlying island were run by the government of Hawaii. You hear of some hospitals that are currently run by others, but the chief ones are run by the Hawaii government. As things were along, I received a call from my former employer, the City of Los Angeles, which was running into a problem in terms of mobilizing their remaining medical facilities.

SACHS. The remaining medical facilities of the city included the City Receiving Hospital operation which was the structure, the old Georgia Street facility. At that time they had the equivalent of paramedics. They would come out of that Georgia Street building Receiving Hospital. Then there were the pre-placement exams, for fire, police, and civilians, plus the occupational health and safety component. Because some events, particularly the shooting of Bob Kennedy and the lack of resources in that neighborhood, the council was up in arms about whether to finance a better facility, or turn it over to somebody else. At that time it was realized that to build other hospital facilities there was not appropriate and

that we ought to close the Receiving Hospital because it was inadequate. It was an emergency center. It could not compete with other hospitals in the neighborhood or the university hospitals that existed. What was better to do was to turn the emergency service over to the Fire Department. As you know, that has grown into a huge system of paramedics working at fire stations, which was more than we had at the Receiving Hospitals; we had one station there. However, the principle, though, remained of dividing the City into sectors, following a program of Fire Department selection and location. So that was something yet to unfold and to close the Receiving Hospital, a hospital of 47 beds with eight patients. It was a very expensive operation in terms of running 24 hours a day, seven days a week. But we accomplished that in three months and just made a health station out of it, supporting six patients. What they do are placement exams and have their industrial hygienists say that “these people are okay.” That in itself is quite an operation when you have something like 40,000 employees and turnover. Their needs and examination for placement, particularly the police and fire personnel, got to be very specialized. Having accomplished that, I looked again at the counties, including Los Angeles and the approaches to serving the public: the combination of hospitals, public health department, mental health department, and veterinarian department. I was attracted by the opportunities to help out. In 1972, I became the deputy in charge of the public health activities for all of Los Angeles County.

FELDMAN. There were various city departments: Pasadena, Long Beach, so forth; have they all come in?

SACHS. No. Pasadena remains separate. They receive money on a firm basis. Long Beach remains independent, and the City of Vernon remains independent. The County Department is financed by LA County. The other three installations are under contract to provide their own services. Well, the approach that the administration had in the Department of Health Services was a network of health centers giving primary care, which is hands-on first call, so of speak, of the patient needing services. It sounds like an excellent idea: the sick patient needs to go to a larger center or a hospital and transfer the records from one to the other. This great theory didn't work out, understandably because of not furnishing the medication or, first, the help which was needed to see the patient on a neighborhood basis, to take care of the people in need in terms of doctors, nurses, drugs and the like. When they started out they used the funds of the public health installations, and those ran out in six months. Then the hospital, being independent, would not help in terms of furnishing manpower and drugs. All that was left was to cut back. We could push service in the health center, which wasn't too wise. Most had cut off more than they could digest, so to speak, and that had been the center of discussion even to the present time: how to handle preventive medicine in public health activity along side the medical care that patients need. Some very good development had come about in the system of neighborhood clinics, neighborhood health centers in meeting the needs of these patients in terms of primary care problems. Now it is irrelevant. In the matter of protecting the public by seeing the patient and by the techniques for preventing the spread of the disease. The patient would not be seen today.

Previously that protection from some of the communicable diseases, specifically venereal diseases, tuberculosis, acute measles, dysentery, and whooping cough, and the like, was a right to that protection. As a citizen, I would like that protection for the tax money I am paying, but now in many services that patient has to pay. In many instances this prevents the patient from getting the services; he carries the disease which could spread from the primary-source patient. That was highlighted early today, April 27, by Dr. Patten, who brought out the fact that the transfer of certain diseases, particularly primary and secondary syphilis in a newborn, is rising rapidly because the programs of screening and clinic treatment are not available unless the patient pays $20 just to be seen. The argument would be, "well, they go through a sort of means test in terms of controlling disease." What that means is that they could pay or not. But that would scare many patients away who would rather carry the disease, which could spread, than do anything about paying to having it treated. So a barrier has been built up and it is all in the basis of administrator overhead that has occurred in the health department activities and, I suppose, in the hospitals as well where the administrator would come along and dictate the program and thinking of this in terms of paying one's own way rather than in terms of education and taking care of the patient who is in need and protecting the rest of the community. I think the taxpayer pays enough for protection and isn't getting any. The administrator now tries to dictate how to control a disease by the number of persons in the activity, and by the difficulty in obtaining drugs. The state of the art changes from time to time in terms of some diseases. That is causing a crisis and I don't know

whether the public would be aroused by this or what is to be done other than the fact some of reorganizing the principles of preventive medicine. That is about where we are today in that activity of trying to protect the public, to enhance the activities in using personnel and newer drugs, and failing, though these diseases are spreading.

My career with the Health Department ended when I became 65 years old. I was on the crest of the wave of investigation of nursing homes, which again was a clash of approaches regarding betterment of nursing homes. Let me say at the outset that the nursing homes we had in ’72 were not any better or any worse than the nursing homes read about in the newspapers today. They are trying to maintain a level of service which is high standard without financing the application of that service. In other words, if you have a proper ratio of nurses to patients it is hard to save money. The first thing was to cut down the amount of nursing service, trying to substitute for that with a lower level of nursing care, or by cutting the amount of money spent on food. This is really a conflict between the patients’ needs versus who is going to pay for the care, and how. When this was first bought to the public’s attention in ’72, one approach was an educational program for the nursing home administrators in terms of type of help they needed, for what purpose, how to train them, how to recruit them, what to do about it, what to pay them; versus an approach designed at that time to push action, go in there and inspect and find defects, close them down, and really get tough with them. Well, that approach and program haven’t improve the level of service one iota. When you run into any police action you get into the courts.

When you get into the court you get injunctions, lengthy delay in trial setting. What do you do in the mean time if there is some infraction of rules and regulation?

At about that time I got more interested in the needs of the diseases and needs of the senior citizen who occupied most of the nursing homes, and the application of what resources we might have for these services particularly for the frail elderly. For years, I was spending most of my time with the Area Agency (for Aging). Since my retirement, I've been active in an area agency and, particularly, in terms of running programs for the elderly. That included the county's feeding of meals—Meals on Wheels—and all that is done by the county agency in a contract arrangement. We would look over the needs of the individual agency's five-year plan, which we monitor as members of the area council which is called in order to receive their funds and you see the changes in terms of the inventory and the need of these patients. Case management has almost gotten to be a buzz word: it brings in a team of nurses, social workers, and doctors. Hospitals like to refer to the person or agency that best conserves the patients needs, so we inventoried the needs of the patients. Right now there is significant program developing, where five departments of the county are getting together to have one record for a client that would go to the department of Health, Department of Mental Health, the area agency, the Probation Department—the Public Guardian Department. The fifth one is the DPSS. That program is there to enhance and bring together the services that a patient needs in the first stages. You have one overall record, and a direction as to who is the

defined primary mover, so to speak, to get service to the elderly through whatever county support there is. It is mandate of the County Board of Supervisors that the Department of Community Services is part of this bureaucracy. It is a program that follows the principle of combining the various departments in the case management approach in five different areas of the county. Hopefully, this will be the model: getting service to the client by calling upon one of the five departments to direct their efforts towards meeting the need. I served on a board of the Area Agency Council, which was an adjunct to the area agency. We also watched legislation and were very much interested in a California Health insurance plan; at this time that is becoming greater issues than I think many people realize. In fact there are some four and a half million people in the state of California who are not covered by any type of health plan or insurance and this is getting to be very costly. You see the application of this difficulty when more than 50 percent of the people going to the trauma centers cannot pay for the services; therefore, the hospitals and the trauma centers are backing off. You hear about the rising interest in the mortality rate of mothers who are not being seen in the clinics because they have to put down money, and MediCal doesn't take care at all of workers who have mental illness. There is a furor about better maternity care and infant care, mind you, if a mother who has a complication in pregnancy prematurely gives birth: the cost to the county somewhere around $25,000 for each case. Even in this respect the infant mortality is going up because there is a problem with the care. It seems to me that the program should pay to get that mother seen when she has some

complications of bleeding, of malnutrition in a life that would give rise to a premature baby; that she be taken care of not in a separate program, but a part of a total insurance program that would cover the trauma center, cover the maternity care, cover the infant care, cover the public health activities, cover the demands for payment over long term care. These are all items that are in a program such as the Canadian Plan, passed and put into effect in Massachusetts recently. I hope it lights a fire to develop further in the United States. We don't have a bandaid program where various programs help. We need one program to cover the needs of the person, and one is coming before the State Assembly—a constitutional amendment that has to be passed by two-thirds of the legislators. The constitutional amendment would be covered by a referendum for financing; there the scheme is coming up where taxing the gas reserves as they come out of the ground, which has never been done in this state but is done in many other states to pay for service to cover all residents of California. Right now the elderly patients are covered by Medicare; MediCal is paying five billion dollars for service. The employer has programs for the employee but in many instances—most—it is not a program for the dependents, and then you come to this huge stock pile of four and half million people who are not covered by anything.

FELDMAN. This is all aside from the immunization?

SACHS. It would include everything, like a Kaiser Plan, for everybody. What it calls for is a commission being established to okay the plan, similar to the Kaiser Plan, for all people. Various agencies who want to establish one would have to meet certain requirements and the service would be paid for by a premium. If

anyone can't afford to pay, the state would pay $600 billion dollars, about $1600 for family per person. But that and the finance through the oil tax, which is kind of enlightening, is getting to be very popular now—coming up with some plans because not all of the manufacturers or politicians, and the person who needs service are beyond themselves as how to finance and how to get such service. So that is one thing my service with the area agency: how to get support for this type of activity; it is very current.

Another one that I am into, a type of activity which is very current is the Visiting Nurses Association. That is a home service for patients referred to the agency. We have seven offices throughout the county, covering all the county. Outstanding is the hospice program for terminal care due to cancer, financed by government funds. In this you need services for one year per family with terminal illness. There are two support programs which offer a group therapy type of service to children of a family where there is a death due to cancer—death of a sibling or a dear one that leaves these kids bewildered by the impact of death in the family. We have two stations to give this service and it has been very successful, but needs more funds to finance it and we are seeking funds to help these people and, also, the 150-odd volunteers who are in this program who consult with families where there is cancer, and for the hospice programs that has been very successful.

I am on a committee for utilization review, proper licensing for people who have to review the cases to see that the service rendered is adequate. One of the other activities that I stayed with is the Public Health Foundation, which is of

interest in terms of bringing to the community things that the Department of Health Service doesn't see fit to do. As an example, we have an infant care program which supplements food for mothers-to-be, and provides children with supplementary food. We have something like $85,000 clients, 350 workers. It seems tome with this funding being available somebody in the community ought to be doing it too. The Health Department chose not to carry out this program because of the hiring of 350 more people which they'd be responsible for, so we are on a contract basis with the Department of Agricultural to carry on this program.

FELDMAN. And who hires the people?

SACH. We don't run the program. We have a manager for the Health Foundation and we have a contract and the money to pay the salaries and benefits. But we brought the program to the community in 1968, I believe, and it has continued as a very good program. My interest in it add that it brings the community back to the community with the tax dollar to buy services available; if we didn't offer the service, the money would go some place else. Some 89,000-odd clients are in need of this: they are in the program because they are in some phase of malnutrition, which, again, would lead to prematurity, toxins, that kind of thing. We also have contracts with the state in terms of public health investigators follow through contract in locating venereal disease patients. I haven't mentioned AIDS. AIDS is something like the tail leading a dog. Huge amounts of money go into AIDS and the need is for services that we find in

hospitals: terminal care and treatment, constant drugs, etc. That is a whole new service that I am not involved with at the present time.

So I go to use my voluntary time with three enterprises and find it fulfilling. It brings me in contact with a lot of programs and gives me a lot to do in my retired years.

FELDMAN. Ralph, let's back up a little to the years that you were the City and the County Health Departments. I recall that you were active on committees in the Welfare Planning Council, the Mental Health Development Commission, and other. In particular, what do you think a public health official can contribute to the voluntary social agency?

SACHS. Well, things change over the years. We mentioned the Welfare Planning Counsel. At that time they were really the group that would look into the needs of the community in terms of social agencies of all types, clinics, health education, and others. This has gotten sort of fractionated. There are groups now who take pieces of a little bit of the planning, like the Long Term Care Group that's made up of many professionals and they try to find how to serve the clients through a case management approach.

FELDMAN. Under what auspices?

SACHS. Professionals getting together. They are not under any umbrella. The only umbrella which I haven't gotten into, for the lack of time, is the United Way. They have their difficulties. There is a lack of funds but this group, Long Term Care, for instance, would like to be known as the agency to come to though they are not incorporated or anything to discover where the need might be for an

Alzheimer center, a need for a day-care type of medical care, of thing. In their work, they would come with locations—a sort of planning group in that respect—if they would be recognized. I can't think of their name, but there was a group that was organized when the funds ran out for the regional planning type of thing, which would be supplemented by the Welfare Planning Council, then it got mixed up with politics and underfinanced, and away it went. In the old days when a council would get together, supported, I think. Those days, if I am not mistaken, are gone. Some of the disease entities established their own approach: the old TB Society is how the American Chest Group Association, that type thing—not only for education but service; they have their focus on chest diseases. Then you have the diabetes people and the arthritis people. All this has gotten fractured in terms of the organization for support in terms of community health. It ought to be coordinated; there ought to be some coordinating council like the Welfare Planning Council was at one time.

FELDMAN. The Council of Social Agencies that then became the Welfare Planning Council.

SACH. That's right. They got together and maybe through United Way they still do; I haven't heard lately. The cancer, the heart, the diabetes, the arthritis organizations: I don't know if they meet together at this time. But the coordinating type of thing is needed about how and when best to apply service programs. Now, what happens is that other communities I don't know, but here they all claim they have plenty to do in their own little dimension and so carry on that way. I mentioned sitting on boards of mental health, TB, and others. We

need to look at the whole person and involve the community as a whole in serving the needs in a community, bringing many things together in a social approach to whatever the needs might be, whether the service is private or public, and how the pieces can make up the whole pattern of meeting needs.

FELDMAN. Well it may be that when we finish this series of oral histories, we will find a pattern for coordination. Ralph, thank you very much. I think you made a really great contribution in giving us this rundown on your life in the arena of public health.

ABSTRACT:

Dr. Ralph Sachs, with a M.D. and additional study in the field of public health, served as a public health officer in Los Angeles City and Los Angeles County, was employed for seven years in India and Pakistan furthering the public health, taught and conducted public health projects under the auspices of the University of Hawaii—this work taking him to many parts of Asia and the Pacific Rim. He was active professionally with nursing homes and as a professional and volunteer in the field of aging and various social agencies. This interview describes his role in the arena of public health, some of the principles he endeavored to apply, and notes some of the problems and needs in the field up to the time of his retirement in 1972 and thereafter as a participant in the activities of various organizations concerned with health care.